PROJECT CONCERN INTERNATIONAL

CHILD SURVIVAL X :
Improving Immunization Coverage and Village Health Post (posyandu) Implementation

September 30, 1994 - September 1997

FINAL EVALUATION REPORT

September, 1997

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EXECUTIVE SUMMARY

(a) Statement of Purpose

Project Concern International (PCI) has been involved in health and development activities in Indonesia since 1972. In the Province of Maluku, PC1 worked with the Ministry of Health (MOH) from 1991 - 1994 with tiding from the USAID grant Child Survival VII (CS-VII) to improve Maluku's village *Posyandu* (integrated health post) program and immunization coverage. Actual implementation of such activities is the direct responsibility of the MOH. The primary role of PC1 has been to provide training, promotional materials, and system support. Under Child Survival X (CS-X), 1994 - 1997, PC1 has continued training to strengthen health service delivery; expand several successful pilot health promotion activities; and introduce the first HIV/AIDS information program. The development of a local partner organization, ***Lembaga*** *Partisipasi Pembangunan Masyarakat* (LPPM) has been a critical input toward achievement of CSX objectives and sustainability of CSX and other health-related activities.

LPPM evolved for several reasons:

- to form both a legal framework and functional entity among local individuals committed to sustaining health development activities throughout Maluku, once PC1 had left the area;
- to provide local individuals with practical experience, and an adequate time frame, in implementing and managing community health projects; and
- to enhance CSX project activities and diversify PCI's project portfolio by seeking in-country grants that, otherwise, could not be obtained by a international PVO.

LPPM staff has benefited from more than two years of hands-on experience in project planning, implementation, and management as well as in fundraising. Currently, LPPM is sub-contracting with local non-governmental agencies, provincial and district ministries, and international PVOs. PC1 will continue to support LPPM (and other local NGOs) in their continued development through a USAID-funded Matching Grant Project ('1997-2000) that focuses on HIV/AIDS in the workplace.

The purpose of this final evaluation is to assess achievement of project objectives; assess improvements in capacity of the project's partner; to examine sustainability of project activities; and to identify and document the achievements of project and staff.

(b) Evaluation Methodology

The final evaluation of PCI's Maluku-based CS-X was conducted from September 1 - 14, 1997 by a team selected by PCI/Maluku and approved at HQ in San Diego. The evaluation team selected by PC1 included a public health consultant, one central DOH staff, and one PC1 staff member from Africa.. USAID-Jakarta staff members were not able to attend. The team reviewed project documents including CS-VII final and CS-X

mid term evaluations, baseline and final survey results, and project materials. Field visits were conducted near the capital of Ambon and in two subdistricts of the district of Southeast Maluku (See Appendices 1 through 3 for team composition and schedule).

The team observed training, *Posyandu,* and school activities The team also interviewed a variety of people related to the project, including government officials, health center staff, community leaders, teachers and school principals, and project beneficiaries. A participatory self-evaluation approach was encouraged through inclusion of PC1 staff in evaluation discussions. The team, together with PCI, presented the final survey results and relevant conclusions and recommendations to the provincial level health staff before finalizing the evaluation report.

(c) Main Achievements and Constraints

The final evaluation team was impressed with the achievements of PCI's project in the Province of Maluku. The project achieved most of the 11 objectives that were set in coordination with governmental counterparts in Maluku Province. Most planned and approved activities were completed. Quality and quantity of data available to document these achievements was excellent. Particular achievements are described below.

- Almost all of the project objectives have been met, as measured by baseline and final survey results. Quality of activities also appears to have met local needs.

- PC1 is, clearly, well accepted by the government as a partner in development, and as a resource for current and future activities.

- The following key innovations developed by PC1 under CS-VII and CS-X, have been adopted by the provincial government. Some of these strategies are being considered for either field-testing or replication in other provinces or nation-wide adoption.

    - School ***Posyundu*** program *(PPAS)*
    - *PAMUPIN*, schoolchildren escort system for National Immunization Days (PIN)
    - *Manise* computer immunization monitoring program
    - Tetanus Toxoid lifetime card and national policy
    - Immunization of ***all*** women of childbearing age for tetanus at ***posyundu.***

- LPPM continues to work toward sustainability, now, having sound technical capacity, internal management systems, and ability to attract funding.

- The PCI-LPPM portfolio and agenda have attracted additional donor funding to expand and complete project activities. Other donors (including AusAid, UNICEF, New Zealand Embassy) are now interested in continuing many of the activities begun under CS-VII and CS-X as Maluku becomes a priority for development.

Constraints to project activities have included logistics of vast distances, poor transportation, inflation, and limited number of staff. Delayed, reduced, or canceled funding from project partners and collaborators also required alternative fund-raising and reduced activities. Finally, governmental decisions about project direction, scope, and timing were made, but in close coordination with PCI.

(d) Capacity Building and Sustainability

It appears that this project has left in place a resource pool of trainers within the Government health system at the provincial and district levels. Several activities, including the ***Munise*** immunization monitoring and the *PAMUPIN* immunization support have already been absorbed into the government system, while the provincial government has requested internal and donor funding for continuation of the School ***Posyundu*** Program (currently in 25% of village schools). Trials of tetanus immunization for all women of reproductive age have led to national adoption of this policy and continuation of the lifetime TT cards.

LPPM, now an independent NGO, has staff with experience and particular skills in training, health promotion, and HIV/AIDS prevention activities. At present, they anticipate funding from multiple donors after CS-X and will do well if they remain focused and don't over reach their capacity.

(e) Recommendations

According to final survey results, the project has achieved 9 out of 11 objectives. This can be considered a significant outcome, especially, in light of the fact that activities (ie. immunization), are carried out by the government health system. It appears that the School ***Posyundu*** Program, alone, can be attributed to an even greater impact. However, the following recommendations target areas for improvement and growth.

1. It is important that innovative strategies and lessons learned during this project be communicated to other PVOs and relevant organizations. Specifically, PC1 should promote the success of the use of schoolchildren in the School ***Posyundu*** Program and PAMUPIN program for increasing coverage of primary health care activities.

2. The next stage in HIV/AIDS prevention activities is to move towards behavior change interventions and improved STD case management. Final survey results show that there has been a significant increase in knowledge among community members and health center staff about the transmission of HIV, but there are still considerable gaps (ie. knowledge of prevention) that, if not addressed, will impede any efforts in

behavior modification. PCI/Indonesia's current and future HIV/AIDS project programming should include research of local behavior change interventions and should focus on LPPM's proven strategies, such as peer education. PC1 should begin to contact encourage the MOH to coordinate with WHO for staff training in STD Case Management.

3. LPPM, as a local NGO, will provide a source of skilled and trained staff for future projects and as a potential partner for the government in other donor projects. In the transition to managerial and financial independence, it would be useful to develop a systematic process that stages the transition period. In such areas, USAID should consider funding mechanisms for transition activities.

1. PROJECT BACKGROUND

(a) Project Summary

PC1 began implementing the USAID-funded Child Survival VII (CS-VII) project in the Province of Maluku, Indonesia in 1991. Through this project, PC1 and the Ministry of Health worked together to improve immunization coverage and maternal and child health services in Maluku. The CS-X project, 1994-1997, built upon the achievements of CS-VII in monitoring immunizations and improving attendance at integrated health posts (*posyandu*). It also introduced some new activities, including training in health promotion activities and an HIV/AIDS information component. The overall goals of this project were to decrease infant and child mortality and to prevent the spread and control of HIV/AIDS in Maluku Province.

(b) Project Beneficiaries and Interventions

Please see attached Tables A and B as well as the Detailed Implementation Plan (DIP) for a description of project beneficiaries (including approximately 286,000 children under five). There has been no change in project beneficiaries. Due to a change in national policy, the refresher training of Traditional Birth Attendants (TBA) was canceled. The number of ***kuder*** (village volunteers) trained was reduced by 40% due to funding problems. Unplanned activities conducted were: *PAMUPIN* schoolchildren support for immunization week and pilot ***kuder*** peer training.

(c) Project Site and Population

The Province of Maluku (the former Spice Islands) is an archipelago of more than 1,000 islands straddling the equator in eastern Indonesia between the islands of Sulawesi and Irian Jaya (formerly Dutch New Guinea). It is comprised of one municipality and four districts divided into 56 sub-districts with 1,508 villages. Maluku covers an area of 851,000 square kilometers (equal to the area of Pakistan), 90% of which is covered by water. The two monsoon seasons (May-September and December-March) strongly influence travel and communications in the archipelago.

The population, of 2.1 million, live mostly in rural areas working as farmers (cloves, nutmeg, cassava) and fishermen. The majority of the population is ethnically Moluccan but more recently transmigrants from Java and Sulawesi have altered the proportion. Although Bahasa Indonesia is the major language, more than 133 local languages are spoken. The people are equally divided between Christians and Moslems.

The project served 52 out of 56 sub-districts. Because there are more than 1,500 villages and 153 health centers, it is impossible to show them all on the attached map (see Appendix 5).

The Provincial MOH is administratively divided into two sections:l) The Area Health Office (*Kanwil*) which is the official arm of the central MOH in Jakarta responsible for policy planning, and 2) The Health Services Office ***(Dinus)*** which represents local government and is responsible for operational tasks. At the sub-district ***(kecumutun)*** level, the individual health centers (*puskesmas*) are staffed (ideally) by a doctor, midwife, nurses, health educator, sanitarian and paramedical aides. With a total 153 health centers, some sub-districts have more than one. Each health center has several assisting health centers (total 548) and village midwives ***(bidun di desu)*** whom have only been introduced in the past few years. Most villages still have Traditional Birth Attendants (TBAs). Each village is supposed to have an Integrated Health Service Post ***(Posyundu)*** which meets monthly to provide growth monitoring, health education, family planning and immunizations to the villagers.

(d) Summary of Project Design

The design of the project built on successful activities carried out in CS-VII. Elementary school programs were used to reach mothers through the School ***Posyundu*** Program to influence maternal care, knowledge, and practices in infant and young child rearing. The pilot school program was expanded from ten schools to a target of 624 schools.

In addition, the CS-X project planned to train ***Posyundu Kuder*** -- first in villages that did not yet have functioning ***posyundu,*** then in villages where *kader* drop-out was high and the ***posyundu*** was not functioning well. To help accomplish this goal, the sub-district's ***Posyundu*** Management Team members from the Women's Welfare Movement (*PKK)* and the MOH were to be included in project activities. In the past, *PKK* and MOH had separate training programs and budgets. This project attempted to develop a collaborative effort, so that the strengths of both organizations could be consolidated.

As in CS-VII, the Training of Trainer (TOT) approach was continued for teacher training in the School ***Posyundu*** Program as well as for health educator training, ***Posyundu Kuder*** training, and the HIV/AIDS seminars. The further development and expansion of the LAM software, MANISE, was to assist not only the province in immunization data management, but also the central MOH in Jakarta upon national expansion of the program.

Project emphasis has been in health education. In order to strengthen the MOH's capacity in their delivery of health education, a ten-day TOT course was planned at the provincial level for district-level health educators, PKK members, and midwives. The HIV/AIDS component was a first effort to develop a health education program, specifically, for rural areas. Information was to be disseminated to village notables (village chiefs, religious leaders, and teachers) who, in turn, would serve as a source of information for villagers. It was agreed that an inter-personal approach would be more effective than mass media in the village setting.

Additions to the CS-X program included the PAMUPIN, or student immunization army, to help increase the number of immunizations during National Immunization Week. PCI/Maluku also introduced a neo-natal tetanus form for use by TBAs in obtaining and recording retrospective data on neo-natal mortality. One major change in the project's design was the cancellation of the TBA refresher course due to Government of Indonesia (GOI) failure to approve the program, despite the fact that US$50,000 had been allocated by UNICEF. In addition, the number of trained ***Posyundu Kuders*** was reduced (as output in the DIP) to five *kaders* from each of 200 villages due to decreased funding.

PCI/Indonesia has a general agreement with the MOH through which technical assistance is delivered to the Indonesian people. While the MOH/Maluku was the direct co'unter-part in the Province, PC1 worked cooperatively with several other government branches (Village Development, Family Planning, Education). Project planning and decisions were made jointly. Other than collaboration with AIDSCAP in conducting HIV/AIDS training, there has been no substantial change in project partners.

2. RECOMMENDATIONS OF THE MID-TERM EVALUATION

A mid-term evaluation of CS - X activities was conducted from April 30 to May 14, 1996 by a team from the central MOH, USAID/Jakarta (technical health advisor) and PC1 San Diego. At that time, several expected funding sources for project activities were delayed or had been canceled. Therefore, the team's primary concern was that reduced funding may make it difficult to achieve some project objectives.

Despite this early financial constraint, the CS - X mid-term team was very impressed with the achievements to date, particularly, with the innovative strategies of *MANISE* computer monitoring, ***PAMUPIN*** immunization support, and the School ***Posyundu*** Program. Their report provided concerns and recommendations for immunization program support, ***posyundu*** implementation, ***posyundu*** attendance, health education, and HIV/AIDS education. Below is a summary of mid-term findings and recommendations (see Appendix 10 for original version).

Immunization Program Support: maintenance of MOH computers for the ***Munise*** program had been problematic, despite PC1 assistance. The "immunizer trains immunizer" (*jurim* ***trains jurim)*** program stopped after 10 trainings because the DOH did not wish to fund *jurim* travel. PC1 has printed and distributed 200,000 lifetime TT cards for Maluku, while the local government awaits durable plastic cards funded by UNICEF for national use. The ***PAMUPIN*** program was expanded to cover all schools and, approximately, 120,000 students to escort mothers and babies to the immunization post. During 1996 and 1997 these two programs were managed by local government.

Posvundu Imnlementation: PC1 had been requested to train up to 10,000 ***kader*** (village health volunteers). However, the USAID-requested funding and subsequent GO1 funding for this activity did not materialize, thus, the DIP target was scaled back to 1,000 ***kader*** (using AusAid funding). A pilot ***kuder*** trains *kader* project was fielded to assess cost effectiveness for a later increase in training numbers. Finally, an assessment of ***Posyundu*** Management Team (PMT) systems for intersectoral coordination was cancelled due to lack of interest.

Posvundu Attendance: ***the team*** felt that the School ***Posyundu*** Program and the social marketing activities (ie. bumper stickers and radio quiz shows) were innovative, successful strategies and, further, recommended that they be expanded. The School ***Posyundu*** Program is now in 25% of schools and the government has agreed to further expand, using their own funds. In view of cancellation of the originally planned TBA training, PC1 obtained additional funding for TBA training in 6 villages in the subdistrict of Kei Besar.

Health Education: the team reported that the health system's training plan was carried out on schedule and that training modules were of high quality. However, there were several recommendations for improved implementation of the School ***Posyundu*** Program. For example, a PCI-developed checklist intended for use by school supervisors ***(penilik),*** had only been used by PC1 staff. Integrated management of the School ***Posyundu*** Program and the existing School Health Education (*UKS*) program is now under discussion, and with the end of CS-X, becomes the prerogative of the government.

HIV/AIDS Education: the mid-term team suggested that PC1 concentrate not only on increased information dissemination, but also on incorporating behavior change communication together with STD management interventions. To date, efforts to obtain funding for additional activity has not been successful. One recommendation is that LPPM begin these activities under (other) HIV/AIDS-related project funding (ie. Matching Grant, 1997-2000).

It is clear to the final evaluation team that PC1 has made every effort to respond to the concerns and recommendations noted at the end of the first year. For example, PC1 shifted resources to better implement and supervise successful programs such as *PAMUPIN*, School ***Posyundu*** Program, and social marketing activities. In addition, PC1 has conducted a diligent search for alternative funding sources in order to expand successful activity, increase program coverage, and to further develop in areas like HIV/AIDS behavior change.

There are some program weaknesses for which recommendation may be beyond PCI's agenda and capability. PC1 has little control over policy for and implementation of government activities such ***as penilik*** (education supervisor) monitoring among teachers; and for logistics like budgets for PMT travel and meetings for intersectoral coordination of ***Posyundu*** activities. In fact, one of PCI's strengths has been to work within and around these constraints in developing "good" working relationships with local government counterparts.

3. CAPACITY BUILDING AND SUSTAINABILITY

(a) Related Health Activities

PC1 is one of the few international NGOs to work in Maluku Province of Indonesia. PC1 does not provide services directly. Therefore, institutional capacity development is a prime focus of the project. All of PCI's activities are implemented and coordinated with the MOH or Ministry of Education and Culture (MOEC). PC1 works with the government at every level from the provincial ***(propinsi) to*** the district ***(kebuputen)*** and sub-district ***(kecumutun)*** and, finally, the village ***(dew).*** The main project activities are connected with the village school and *posyandu*. PC1 has a close relationship with the government and community as shown by provision of office space within the MOH in two outlying district offices and close cooperation in the recently completed HIV/AIDS training for community leaders.

The goal of the project has been to increase the coverage of vital MCH services through encouraging increased attendance at ***posyundu*** by mothers. This means PWLPPM had to strengthen its interaction with five districts and 52 sub-districts throughout the province. This has involved an innovative linkage for primary health care through utilization of schoolteachers and students to encourage women to attend ***posyundu.*** In the process of setting up the School ***Posyundu*** and PAMUPIN programs, PCI/LPPM has had to develop working relationships with community leaders, health center personnel, school staff, and students. The government has invited and even paid for PWLPPM to conduct seminars for their staff in HIV/AIDS and health education both within and beyond CS-X.

PC1 continues to be instrumental in maintaining and developing the MANISE computerized monitoring program for expansion to other parts of Indonesia. Private businesses have contracted LPPM for training in HIV/AIDS and Christian schools have solicited school ***posyundu*** training for their institutions. Another measure of the community's willingness to work with PC1 is their trust in allowing PC1 to conduct frequent house to house surveys in their villages.

(b) Continuation of Project Activities

Perhaps the strongest achievement of the program has been the attention paid to the continuation of the activities after CS X. It was for this reason LPPM grew out of PC1 Maluku. Even during the CS X project, LPPM has been able to obtain additional funding for its project activities from AusAid, the New Zealand Government, the British Government, AIDSCAP, BASICS, Union Texas Company, Unilever Company, and various Christian schools. More importantly, the Indonesian Government has contributed to the cost of the program, particularly with regards to health education training, printing of TT cards, HIV/AIDS training, and the PAMUPIN program. In fact, the Indonesian government increased the PAMUPIN program from 840 schools to more than 2,200 schools and funded 95% of the activity in 1997!

The Indonesian Government will continue several of the activities initiated in CS X. Some of these will continue with the support of LPPM. The *MANISE* immunization recording system has been adopted by all of Maluku's districts. In addition, trials will be held in several other areas of Indonesia including Kalimantan and Irian Jaya, with future expansion pending ADB/GOI funding. With BASICS funding, a generic program has been completed for use at the central, provincial, and district MOH levels. Although the peer immunizer training was effective at improving immunization performance, the government did not continue the program. However, the lifetime TT cards developed during CS X will be distributed nationally and UNICEF will fund the printing of 42,000,000 plastic adaptations of PCI's TT card. The policy of TT immunization for *all* women of fertile age (not just pregnant women), accepted on a trial basis in Maluku, has now become national policy. The MOEC has proposed to continue the school ***posyundu*** training as an intersectoral activity. The local district governments will maintain promotional activities such as radio quiz shows. The peer immunizer training was effective at improving immunization performance, but it is unclear if the government will continue funding. The Central MOH has expressed interest in using the concept in other provinces.

LPPM will continue to implement their community health activities, particularly in HIV/AIDS awareness. LPPM has secured funding from the New Zealand Government to expand ***posyundu*** school training. Other sources of funding include a matching grant from USAID for HIV/AIDS work; McFarlane/Burnett sub-contract for a new AusAid project in two districts; and Community Outreach Initiatives (CORI) sub-contract for training activities in East Kalimantan. Other possible donors are UNICEF, German Doctors for Development, and private businesses. The government has also requested further training from LPPM and will contribute towards some of the costs of this training.

(c) Capacity Building of Local Partners

In capacity building at provincial level, both MOH and LPPM staffs have received management training and technical instruction for monitoring and evaluating programs. This has included computerizing the immunization record keeping system in Bahasa Indonesia which has made computation, graphics, and analysis more efficient. LPPM staff has performed a series of complex surveys together with MOH staff during the course of the project and has been significantly involved in the design and analysis of the surveys.

The project has produced a resource pool of trainers for future health training activities. PCI/LPPM has worked with its counterparts to design and develop a curricula for project training and has assisted the counterpart (usually MOH or MOEC staff) with training of trainers (TOT). The newly trained trainers, subsequently, trained ***Posyundu*** *Kaders*, PPAS and PUMUPIN teachers, and health educators assigned to health centers. Recently, LPPM has turned its attention directly to the community in training leaders as well as health staff about HIV/AIDS. These community leaders, in turn, have returned to their villages to hold information sessions with other community members.

All project responsibilities and those activities considered to be most effective will be maintained by the government and, to some extent, by LPPM. PC1 will continue support to LPPM only in an informal, advisory role after CS X finishes on September 30, 1997. The government will continue the activities initiated under CS X and LPPM will be able to offer training assistance to the government through its externally funded programs. PC1 has successfully handed over all program management activities to the government.

(d) Community Participation

Community members did not participate directly in the design of the project, but their ideas were solicited through focus groups and surveys. Their direct participation can be measured by the increase in attendance at ***posyundu*** over the course of the project and increased coverage at the PIN. Reports of village information meetings held by community leaders (trained by LPPM) in HIV/AIDS are another indicator of community participation. The School ***Posyundu*** Program is designed to increase both short-term and long-term attendance at ***posyundu*** and, in turn, to increase knowledge of students and their parents about child survival activities. School students, as part of their PPAS training, are required to gather health-related information from the community as well as to encourage mothers to attend ***posyundu*** and PIN.

The community did not directly pay for any activities but they have contributed their time to organization of activities. Next year, students may be asked to pay for the books required for the School ***Posyundu*** Program training course.

All community members interviewed in the final evaluation stated ***thatposyundu*** and the School ***Posyundu*** Program were "good" for the community and would like these services expanded. Community leaders were especially interested in continuing HIV/AIDS training and have expressed special interest in using visual aides.

(e) Cost Recovery

Cost recovery was not a specific objective of this project. However, several private businesses invited LPPM to conduct HIV/AIDS training for their employees. Also private companies such as Unilever and Nestle contributed promotional items to the PPAS and to the cost of printing lifetime TT cards.

(f) Capacity Building and Sustainability Plans

[See Table E - Capacity Building and Sustainability Plans and Outcomes]

4. DICUSSION OF FINAL SURVEY FINDINGS

(a) Findings of Final Survey

Three final surveys were conducted using the WHO 30-cluster sampling method. These included separate surveys, with and without the School ***Posyundu Program,*** and an HIV/AIDS information survey among community members and health staff. Evaluation of final survey results shows that the project has met target objectives in 9 of 11 objectives and has exceeded expectations in two of the eleven objectives. The two areas in which targets were not reached may be due to survey methodology problems.

Changes in immunization coverage and knowledge of key child survival interventions, such as ORT and nutrition, were measured in baseline and final surveys and, in all but one case, these indicators increased from the baseline. Across the board, all results were better in villages 'where the School ***Posyundu*** Program was running. Correct knowledge of HIV/AIDS transmission and prevention increased among community members, but the increase was much more dramatic among health center staff.

Please refer ***to Table D: Project Objectives and Survey Results*** for a summary of findings and to the accompanying, completed survey report which includes baseline and final questionnaires as well as survey methodology.

(b) Final Survey Results: comparison of baseline survey to DIP objectives

1. Increase to 85% the proportion of children between 12-23 months of age who are fully immunized by 12 months of age (according to the LAM system) or to 70% by the WHO cluster-sampling system.

There are two indicators used here. The former is the one used by the MOH to monitor immunization coverage monthly. The Local Area Monitoring program shows that coverage based on this method rose to 82% using the ***Munise*** program to obtain the final result at the end of the fiscal year in March 1997.

The second value, using the WHO cluster-sampling system, is population based and requires a different method of obtaining coverage. Generally, the latter is somewhat lower than the former because the population-based method measures only recorded immunizations. As seen in Table D, the coverage rose from 47% in February, 1995 to 6 1 f 10% in June, 1997 (129/2 11). The percentage of children completely immunized was 68 f 10%, but a portion of these children were immunized after one year of age. This objective was achieved.

2. Increase to 30% the proportion of women with proof of receiving two doses of tetanus toxoid vaccine prior to the birth of her last child less than 2 years of age.

This objective was achieved with an increase to 47 ± 10% (106/224) and can be attributed to the distribution and current usage of the lifetime TT card.

3. Increase to 80% the proportion of children under two who possess a Road-to-Health card.

Achieved increase to 69 f 1 0% (154/224) did not meet the target, but was very close. At eighty percent, the project is probably approaching an upper limit of practicality.

4. Increase to 60% the proportion of children under two who attend monthly ***pusyundu.***

Considering the 10% margin of error, one could assume that the final survey result of 5 1% (115/224) achieved the objective. However, there was only a small increase over baseline. It is likely that the closer to 50%, the more difficult it is to raise this indicator. In the more rural areas where the School ***Posyundu*** Program was running, there was a more dramatic rise (29 % to 46%) since the baseline was lower.

5. Increase to 65% the proportion of children under two with diarrhea in the past two weeks who were treated with ORT.

The final result achieved 65% (13/20), but it should be understood that these small numbers don't represent statistical significance.

6. Increase to 25% the proportion of mothers of children under two who know at least two signs/symptoms of dehydration.

This objective was not achieved even with a 10% margin of error. The program relied, primarily, on health education efforts by health center staff and the School ***Posyundu*** Program. However, it ***was*** found that the School ***Posyundu*** Program still has a better potential for teaching the danger signs of dehydration to large populations than does relying on informal health education talks by HC staff. The curriculum needs to be modified to meet the informal needs of target populations. Final = 11% (25/224).

7. Increase to 85% the proportion of pregnant women who deliver assisted by a trained health worker (including trained TBA).

This objective has been achieved, but probably not because of direct project interventions. The proportion of deliveries by trained TBAs remained stable at 63% from the baseline. Since PC1 did not train any more TBAs in the CS-X component, the expectation was, merely, that more mothers would shift to the use of the trained TBAs. The TBA and midwife refresher training would have reinforced this, but the MOH did not consent to the TBA training. Where did the rise come from? The increase to 84% (188/224) occurred, primarily, because of a shift to the use of midwives - an indication that perhaps the village midwife program is beginning to have an impact on the community.

8. Increase to 25% the proportion of mothers who have proof of at least one antenatal visit prior to the birth of her youngest child under two years of age.

In meeting this objective, the intention was to work with the MOH in promoting greater frequency of antenatal care visits. Unfortunately, proof of these visits is still difficult to obtain. A new policy states that each province must print Maternal Health Cards. The project would probably have seen a rise, ***with proof***, if it had printed and circulated Maternal Health Cards. According to maternal histories, the proportion of women who were seen in a health facility for pre-natal examination rose from 80 to 98%.

9. Increase to 80% the proportion of mothers who sought medical treatment for their infant/child less than two years old with cough and rapid, difficult breathing in the past two weeks.

This objective was achieved although the sample is small. Final = 81% (21/26).

10. Increase to 70% the proportion of health center staff who know the etiology of AIDS *plus* at least two means of transmission ***and*** at least two methods of prevention.

The fact that the final survey indicator question was not worded exactly as the baseline survey question (an oversight due to refinements in survey techniques over the lifetime of the project) causes some inconsistency. However, the rise from 32% to 95% (40/42), most likely, surpasses the target of 70 percent.

11. Increase to 30% the proportion of people 15-49 years of age that know at least one mode of transmission ***and*** at least one method for prevention.

This objective was achieved, although variation in the wording of indicator questions occurred. Any error due to differences in wording would still put the indicator over the targeted 30 percent. However, this project can not take full credit for the improvement in community knowledge, as the media began to carry out more information to the rural masses during the implementation of CSX. Final = 79% (265/336).

5. ISSUES IDENTIFIED BY THE FINAL EVALUATION TEAM

Although there are no issues that significantly impact achievement of the project objectives, there are some concerns expressed by the project members and the evaluation team:

- Project staff were disappointed not to have had more involvement from the USAID Mission. Although USAID team members were invited to participate in the final evaluations for both CS-VII and CS-X, there was no USAID representation at either evaluation.

- Both the project staff and evaluation team suggest that more than two weeks time be scheduled for (future) final evaluations in order to better investigate and prepare the final report.

- The evaluation team appreciates the efforts made to fully cover all of Maluku Province by PCI. However, the scope of the evaluation has caused the project staff to be overextended and has possibly affected the quality and potential impact of other work. It is hoped that LPPM will narrow its geographic focus and, perhaps, its project focus in order to continue providing quality services.

6. INNOVATIONS AND LESSONS LEARNED

(a) Innovations

There were four project activities that should be singled out as innovative strategies:

- The ***MANISE*** immunization record keeping software in Bahasa Indonesia has been adopted by the government throughout the province and is now being used in several other parts of Indonesia. A generic version of the software (funded by BASICS) has been completed for use at the Central MOH, once funding for expansion is made available.

- The ***PAMUPIN*** program, which employs students to escort mothers to the National Immunization Week ***(Pm)*** posts, has resulted in an increase of both PIN attendance and polio immunization coverage for all three *PIN*s, 1995-97. A survey conducted in 1995, after the PIN, revealed that coverage was 92% in sites where ***PAMUPIN*** was used and only 83% at sites without ***PAMUPIN.*** The government adopted the program, as per its own initiative and expense, expanding it from the original 840 schools trained by PCI/LPPM to an estimated 2,200 schools. This program was showcased during the Minister of Health's 1997 nationally televised ***PIN*** site visit to Maluku. An article about this program has been accepted for publication in ***EPI Update,*** a WHO publication.

- The school ***posyundu*** training program utilizes teachers and students to encourage increased attendance by mothers at ***posyundu*** sessions. Students in grade four learn about ***posyundu*** subjects such as immunizations, vitamin A, and ORT. Each student is assigned to escort and follow at least two village participants with children under three years of age. This program has resulted in increases of ***bothposyundu*** attendance (from 29% to 46%) and in complete immunization coverage for children less than two years of age (from 38% to 64%). The provincial MOEC has proposed to continue the program as an example of intersectoral cooperation and has already requested funding for 1997-98. The New Zealand Government has provided funds to LPPM to expand the number of PPAS schools in two districts. The PPAS program is currently being tied in other parts of Indonesia such as Kalimantan and Irian Jaya. This program has been presented nationally and described in local publications and in a report to the MOEC. PPAS survey results will be presented in a report to the national Ministry of Education, at the request of the Minister, in December.

- The peer immunizer-training program was an innovative program that attracted funding from BASICS. Unfortunately, despite the improvement in immunization rates where the training took place, the government was unable to provide the necessary resources to continue the program. The program has gathered outside interest with a presentation given at the 1997 National Council for International Health Conference in Washington, D.C. and is pending publication in the WHO ***Bulletin.***

(b) **Lessons Learned**

One lesson learned is the effective and important use of teachers and students in mobilizing the community for health activities. This intersectoral approach has improved community participation and increased immunization rates and knowledge of child survival skills among mothers and students.

Development of a local partner organization has enhanced the overall success and sustainability of the program activities. However, future programming should reflect a formal, deliberate process for their development and transition toward independence. One suggestion is that the partner organization begin to assume a greater percentage of its own core funding in addition to project activity funds.

7. ACHIEVEMENTS AND CONSTRAINTS

(a) Meeting Project Objectives

The final evaluation team was impressed with the achievements of PCI's project in the Province of Maluku. With very few exceptions, the project achieved the objectives (9 of 11) agreed by the Provincial Government and completed most planned activities. The quality and quantity of data available to document these achievements was excellent. See Table D for the quantitative summary of objective targets - baseline and final.

(b) Achievements of Project

PC1 and LPPM have much to be proud of in the development and implementation of a program that works, primarily, through the local government health system. Many decisions about the project's direction, scope, and timing were the responsibility and prerogative of the implementing organization - the Government of Indonesia. Successful implementation of planned activities is, largely, due to a "good" working relationship with the local government. Flexibility has been important, as witnessed in the ***PAMUPIN.*** This program was planned and developed, after completion of the DIP, to assist the government in its National Immunization (Polio) Campaign. In several circumstances, promised funding did not materialize, but staff took the initiative to find alternative sources.

Particular achievements of this project are:

- PC1 and LPPM have been acknowledged by the government as implementing partners and are considered as resources for on-going and future activities.

- Several key innovations developed by PCI, under CS-VII and CS-X, have been adopted by the Provincial Government and some will be adopted on a national level. Particular innovations include:

    - ***Munise*** computer immunization monitoring program
    - School ***Posyundu*** Program
    - ***PAMUPIN*** program, managed by the local government in years 2 and 3.
    - Field-testing mechanisms for TT immunization coverage among all women of fertile age
    - Lifetime TT cards to be adopted and funded nationally by UNICEF

- Ability to expand key interventions during CSX, in particular the School ***Posyundu*** Program and HIV/AIDS activities, as a result of donor interest.

- Continued donor interest and funding (ie. AusAid, UNICEF, New Zealand Government) to expand CS-VII and CS-X project activities.

- Development of a local partner which, now, has the technical capacity to attract funding for future activities as well as to continue and expand current child survival and HIV/AIDS related activities

Logistical constraints to project activities have included vast distances compounded by poor transportation, inflation, and limited manpower (among a small PC1 staff). On the other hand, achievements can be attributed to both improvements in local governmental operation and, especially, to the dedication of the local PC1 staff. Working in 52 of 56 sub-districts over a vast area (size of Pakistan) and under difficult logistical conditions has, clearly, tried their capabilities in implementing *all* planned activities in a professional, timely manner.

(c) Difficulties in Implementation

Major activities that were not followed to term as planned are the refresher training courses for TBAs and the training of additional *kaders*. The former was due to a change in GO1 national health policy, whereby, funding earmarked for TBA refresher training and distribution of iron tablets was cancelled. ***Kuder*** training met only 59% of the planned target because of difficulty in raising necessary funds. However, to their credit, project staff appeared to have made every effort to secure such funding.

The "immunizer trains immunizer" program has been recorded as being successful. However, even though evaluators from the BASICS Project found it an effective method to increase immunization coverage, the local government does not appear to have accepted the concept or to have thought it a priority for funding at this time. The reason for their decision remains unclear.

Finally, the local government in Central Halmahera District canceled some of the HIV/AIDS program activities. The project had obligated funding for several activities with the expectation that the local government would then refund these expensed monies or pay for other activities. This situation appears to have been exclusive to Central Halmahera District.

TABLE A: FIELD PROJECT SUMMARY - DIP

PVO Country PCI/Indonesia-Maluku Project Duration (mmlddlyy) start date September I, 1994

1. BUDGET SUMMARY IN U.S. DOLLARS

(a)	(b)	(c)	(d)
a. By year of project	USAID Contribution (field + HQ)	PVO Contribution (field + HQ)	Total Contribution (field + HQ)
Year 1	$412.719	$156.638	$569.357
Year 2	$360.281	$171.189	$531.470
Year 3	$417.634	$69.047	$486.681

b. Percent of PVO Match	25%

(PVO Contribution divided by Total Contribution: sum of column "c" divided by the sum of column "d")

3. PRECENT OF TOTAL USAID CONTRIBUTION by INTERVENTION

Percentages must add to 100%

INTERVENTION	Percent of Project Effort (%)	Percent of USAID Funds in US $
a. Immunization	55	$654.849
b. Control of Diarrhea1 Diseases	5	$59.532
c. Nutrition		$0.000
d. Vitamin A		$0.000
e. Iodine		$0.000
f. Control of Pneumonia	5	$59.532
g. Maternal Care/Family Planning	25	$297.659
h. Malaria Prevention & Management		$0.000
i. HIV/AIDS	IO	$119.063
j. Other (specify)		$0.000
k. Other (specify)		$0.000
l. Other (specify)		$0.000
m. Other (specify)		$0.000
TOTAL	100%	$1,190.635

2. SIZE OF THE POTENTIAL BENEFICIARY POPULATION

Note: POTENTIAL BENEFICIARIES are defined as those in the project area who are Eligible lo receive services for a given intervention, not the precenl you expect to provide services to -which may be than the eligible population

(e)	(f)
a. Current population within each age group*	**Number of Potential Beneficiaries**
infants, O-l 1 months	58,000
children, 12-23 months	55,000
children. 24-59 months	156.000
children, 60-71 months (if Vitamin A component)	
females, 15-19 years (high risk pregnancy)	
females, 20-34 years	581,000
females, 35-49 years (high risk pregnancy)	
Other (specify) Men 15 - 49	540,000
Other. (specify)	

b. Additional births	
Total estimated live births years 2 and 3	121,000
c. Total Potential Beneficiaries	**1,511,000**

• Note: Females (ages 1549) should only be included as potential beneficiaries where They are direct beneficiaries of services (for example, TT immunizations, or family planning services), and not for educational interventions (for example, educalon on proper use of ORT)

4. CALCULATION OF USAID DOLLARS per BENEFICIARY per YEAR

a. Total USAID Contribution to Country Project (sum of column "b" in table 1, this page)	**$1,190.634**
b. Total Potential Beneficiaries (sum of column "f' in table 2, this page)	$l,51 1 .ooo
c. USAID Funding per Beneficiary for Project line a divided by line b in table 4, this page)	**$0.7**
d. USAID Funding per Beneficiary per year (line c above divided by 3 years)	**$0.2**

TABLE B: PROJECT GOALS AND OBJECTIVES - DIP

PROJECT GOALS: 1. To decrease infant and child mortality in Maluku
2. To prevent the spread and control the impact of HIV/AIDS in Maluku

1 **Project Objectives by intervention**	2 **Measurement Method How/When**	3 **Major Planned Inputs and Activities**	4 **outputs**	5 **Measurement Method Data Source How/When**
Increase to 05% the proportion of children between 12-23 months of age who are fully immunized by 12 months of age (according to the LAM system) or to 70% by the WHO cluster-sampling system.	) Local Area Monitoring system (MANISE) 2) Immunization coverage survey	1) Continue expansion of MANISE with training of MOH staff 2) Development of central LAM program for reporting from province to Central MOH 3) Continued immunizer peer management training 4) Re-training of TBAs	1) MANISE network functioning in all districts with province -> Jakarta 2) Trained Immunizers 3) Trained TBAs distributing RTH and TT cards 4) Social marketing activities: - Radio quiz show, bumper stickers, mass immunizations campaigns - School Posyandu Program functioning - Pamupin - supporting National Immunization	1) Monthly MANISE diskette reports received 2) Baseline/Final survey of RTH card usage 3) Project activity reports on training activities completed 4) Results of training evaluations 5) MOH reports on immunizer training 6) NIW monitoring reports
Increase to 30% the proportion of women with proof of receiving two doses of tetanus toxoid vaccine prior to the birth of her last child less than 2 years of age.	) Local Area Monitoring system (MANISE) 2) Immunization coverage survey	TBAs - -	1) MANISE network functioning in all districts with province -> Jakarta 2) Trained Immunizers 3) Trained TBAs distributing RTH and TT cards 4) Social marketing activities: - Radio quiz show, bumper stickers, mass immunizations campaigns - School Posyandu Program functioning - Pamupin - supporting National Immunization 5) TT cards available 6) Functioning MOH TT monitoring & recording system	1) Monthly MANISE diskette reports received 2) Baseline/Final Survey of TT card usage 3) Project activity reports on training activities completed 4) NIW monitoring reports 5) MOH TT reports to PCI

TABLE B: PROJECT GOALS AND OBJECTIVES - DIP

PROJECT GOALS: 1. To decrease infant and child mortality in Maluku
2. To prevent the spread and control the impact of HIV/AIDS in Maluku

1 **Project Objectives by intervention**	2 **Measurement Method How/When**	3 **Major Planned Inputs and Activities**	4 **outputs**	5 **Measurement Method Data Source How/When**
(Increase to 80% the proportion of children under two who possess a Road-to-health card.	Baseline/final survey of RTH ard usage	1) Posyandu cadre training preceded by PKK and Health Educator TOT courses 2) Social Marketing program 3) Re-training of TBAs in distribution of RTH cards	1) Posyandu cadres trained for 200 villages 2) 50 PKK members and 153 health educators trained as Posyandu cadre trainers 3) Social Marketing activities: - Radio quiz shows - School Posyandu program in 600 schools 4) 1,500 re-trained TBAs	1) Monthly project activity reports 2) Results of training evaluations
Increase to 60% the average proportion of children under two who attend Posyandu each month	Baseline/final surveys of Polsyanduattendance	Same as above	Same as above	Same as **above**
Increase to 65% the proportion of children under two with diarrhea in the past two weeks who were treated with ORT.	Baseline/final surveys	1) School Posyandu program emphasizing use of ORT 2) TBA refreseher training emphasizing ORT 3) Development of Posyandu Radio Quiz shows in all districts 4) Training of district and H.C. Health educators 5) Training of Posyandu cadres	1) School Posyandu program running in 600 schools 2) 1,500 re-trained TBAs providing ORT advice 3) Monthly Posyandu radio quiz broadcast in all districts 4) 153 health centers educators and 10 TOTs trained 5) Posyandu cadres trained for 200 villages	1) Monthly project activity reports 2) Results of training evaluations

TABLE B: PROJECT GOALS AND OBJECTIVES - DIP

PROJECT GOALS: **1. To decrease infant and child mortality in Maluku**
2. To prevent the spread and control the impact of HIV/AIDS in Maluku

1 **Project Objectives by intervention**	2 **Measurement Method How/When**	3 **Major Planned Inputs and Activities**	4 **outputs**	5 **Measurement Method Data Source How/When**
Increased to 25% the proportion of mothers of children under two who know at least two signs/ symptoms of dehydration.	Baseline/final surveys	1) School Posyandu program emphasizing signs/symptom of dehydration PLUS the above inputs 2) through 5)	Same as above	Same as above
Increase to 85% the proportion of pregnant women who deliver assisted by a trained health worker (including trained TBA)	Baseline/final surveys	1) TBA Refresher training 2) Training of midwife TBA trainers at health center and district level TOTs	1) 1,500 TBAs re-trained 2) 153 midwife TBA trainers/ supervisors and 10 district TOTs	Same as above
Increase to 25% the proportion of mothers who have proof of at least one ante-natal visit prior to the birth of her youngest child under two years of age.	Baseline/final surveys	Same as above PLUS 3) Training of district and Health Center health educators 4) Training of Posyandu cadres	Same as above PLUS 3) 153 HC health educators trained 4) Posyandu cadres trained for 200 villages	Same as above PLUS MOH monthly reports of WCH indicators (K-9)
Increase to 80% the proportion of mothers who sought medical treatment for their infant/child less than two years old with cough and rapid, difficult breathing in the past two weeks	Baseline/final surveys	1) School Posyandu Program covering ALRI 2) TBA refresher training covering ALRI 3) Development of Posyandu Radio Quiz shows in all districts 4) Training of district and H.C. Health Educators 5) Training of Posyandu Cadres	1) School Posyandu program running in 600 schools 2) 1,500 re-trained TBAs providing ORT advice 3) Monthly Posyandu radio quiz broadcasts in all districts 4) 153 health center educators and 10 TOTs trained 5) Posyandu cadres trained for 200 villages	1) Montlhy project activity reports 2) Results of training evaluations

TABLE B: PROJECT GOALS AND OBJECTIVES - DIP

PROJECT GOALS: 1. To decrease infant and child mortality in Maluku
2. To prevent the spread and control the impact of HIV/AIDS in Maluku

1 **Project Objectives by intervention**	2 **Measurement Method How/When**	3 **Major Planned Inputs and Activities**	4 **outputs**	5 **Measurement Method Data Source How/When**
Increase to 70% the proportion of health staff who know the etiology of AIDS PLUS at least two means of transmission AND at least two methods for prevention of HIV/AIDS.	Baseline/final surveys of health center staff via W/AIDS KAP	1) TOT course at district and H.C. level for health educators and midwives 2) Develop HIV/AIDS materials for distribution 3) Support Radio Quiz shows in the district	1) Training completed for 153 health educators and 153 midwives plus 10 district health educators and 10 midwives 2) HIV/AIDS seminars conducted for leaders in 1,500 villages 3) Materials distributed to health centers 4) Periodic radio quiz broadcast	1) activity reports 2) Results of training evaluations
Increase to 30% the proportion of people 15-49 years of age who know at least one mode of transmission AND at least one method for prevention of HIV/AIDS	Baseline/Final surveys of :ommunity via HIV/AIDs KAP	1) TOT course at district and H.C. level for health educators, midwives & PKK members 2) Seminars for village leaders 3) Develop HIV/AIDS materials for distribution 4) Support Radio Quiz shows in the districts	1) Training completed for 153 health educators and midwives plus 500 PKK members 2) HIV/AIDS seminars conducted for leaders in 1,500 villages 3) Cue cards distributed to village leaders 4) Periodic Radio Quiz broadcasts	1) Monthly project activity reports 2) Results of training evaluations

TABLE C: CSX PROJECT ACHIEVEMENTS

INPUTS	PLANNED		ACHIEVED		OUTPUTS	% OF TARGET
	NO.	DATE	NO.	DATE		
1. Baseline Survey						
KAP	X	IV/1 994	X	I/1 995	Survey Report	100%
HIV/AIDS	X	IV/I 994	X	I/1 995	Analysis complete	100%
HC Staff KAP - ARI & HIV/AIDS	X	IV/I 994	X	I/1 995	Survey Report	100%
2. Infant Mortality Rate Survey	0	unplanned	X	III 995	Survey Report summited to AusAID & MOH	N/A
3. Detailed Implementation Plan	1	I/1 995	X	I/I 995	DIP completed/submitted	100%
4. Posyandu MT Assessment	X	I/1 995			GOI declined Implementation	C
5. Health Educator Training						
Large Island Groups	3 trainings	I/1 995	3 trainings	II/1 995	4 district teams and 21 island groups (4/group)	100%
6. Health Educator Training						
Small Island Groups	2 1 trainings	II/1 995	21 trainings	III/I 995	135 health centers trained	100%
7. School Posyandu Program Prep.						
- Subdistrict Supervisor Training	3 trainings	II-III/1 995	3 trainings	II-III/1 995	50 sub-district supervisors trained (50/52)	96%
- Teacher training (Phase II	52 trainings	III/I 995	50 trainings	III-IV/I 995	257 teachers & 257 school principals trained	98%
- Teacher training (Phase II)	52 trainings	III/I 995	52 trainings	III-IV/I 996	364 teachers & 364 school principals trained	100%
8. School Posyandu Program						
Phase I	262 schools	IV/95-I/96	257 schools	IV195 -I/96	6,400 4th grade students involved	98%
Phase II	624 schools	IV/96-I/97	624 schools	X/I 996	15,600 4th grade students involved	100%
9. Teacher training for Christian schools	0	unplanned	1 training	II/I 996	Teachers trained for 43 schools	N/A
IO. Computer training for HIS Coordinator	X	II/1 995	6 weeks trng	II/1 995	HIS Coordinator capable of servicing computers/training	100%
HIS Coord. Trainee	0	unplanned	6 weeks trng	II/1 997	Trainee able to accomplish same	N/A

TABLE C: CSX PROJECT ACHIEVEMENTS

INPUTS	PLANNED		ACHIEVED		OUTPUTS	% OF TARGET
	NO.	DATE	NO.	DATE		
1. Peer immunizer training program	X	1995-97	10 trainings	1995	10 immunizers trained BASICS study/evaluation	N/A
2. MANISE used for monitoring	X	1995-97	X	1994-1996	MANISE functioning in 4/5 districts MANISE functioning in province level BASICS grant to expand	80% 100% N/A
3. HIV/AIDS village training						
- HC staff training	135 HC	III/95-IV/95	135 HC	III/I 995	3 staff/HC (300 staff trained)	100%
- Village seminars	135 seminars	W/95-11/96	107 seminars	VI1 997	2,546 people trained	79%
4. Social Marketing program	X	1994-97	X	1994-97	Radio Quiz shows in Ambon/Ternate/Tual TT Bumper stickers distributed 200,000 TT cards distributed	
5. TBA Refresher training	135 trainings	IV/95-III/96	0		Activity cancelled by MOH/National	
6. Posyandu Kader Training	100 villages	I/96 - IV196	1 18 villages		22 subdistricts involved	59%
7. PAMUPIN Program						
- School Activity	0	unplanned	840 schools	III/95	Estimated 37,000 students involved	N/A
			2,200 schools	III/96	Est. 12 1,000 students involved	N/A
			2,200 schools	III/97	Est. 12 1,000 students involved	N/A
- PIN Evaluation Survey	0	unplanned	840 schools	VIII/96-VIII/97	Document completed	N/A
3. HIV/AIDS seminars/workshops						
- 8 workshops	0	unplanned	2 1 sessions	III/95-VIII/97	2,841 particpants reached (see list of workshops)	N/A
3. Final Survey						
KAP	X	VW97	X	IX197	Survey Report	}
HIV/AIDS	X	VII197	X	IX197	Analyzing data	) 100%
HC Staff KAP - ARI & HIV/AIDS	X	VII/97	X	IX197	Survey Report	}

TABLE D: PROJECT OBJECTIVES

	TARGET	BASELINE	ACHIEVED
1. Increase to 85% the proportion of children between 12-23 months of age who are fully immunized by 12 months of age (according to the LAM system) or to 70% by the WHO cluster-sampling system.	85% (LAM) 70% (WHO)	80% 47%	82% 61% (±10%)
2. Increase to 30% the proportion of women with proof of receiving two doses of tetanus toxoid vaccine prior to the birth of her last child less than 2 years of age.	30%	16%	47% (±10%)
3. Increase to 80% the proportion of children under two who possess a Road-to-Health card.	80%	56%	69% (±10%)
4. Increase to 60% the proportion of children under two who attend *Posyandu* each month.	60%	48%	51% (±0066 10%)
5. Increase to 65% the proportion of children under two with diarrhea in the past two weeks who were treated with ORT.	65%	52% (n=50)	65% (n=20)
6. Increase to 25% the proportion of mothers of children under two who know at least two signs/symptoms of dehydration.	25%	11%	11%
7. Increase to 85% the proportion of pregnant women who deliver assisted by a trained health worker (including trained TBA).	85%	73%	84%
8. Increase to 25% the proportion of mothers who have proof of at least one antenatal visit prior to the birth of her youngest child under two years of age.	25%	5%	7% (16/224)
9. Increase to 80% the proportion of mothers who sought medical treatment for their infant/child less than two years old with cough and rapid, difficult breathing in the past two weeks.	80%	67% (n=33)	81% (n=26)
10. Increase to 70% the proportion of health centers who know the etiology of AIDS PLUS at least two means of transmission AND at least two methods for prevention of HIV/AIDS.	70%	32% (n=59)	95% (n=42)
11. Increase to 30% the proportion of people 15-49 years of age who know at least one mode of transmission AND at least one method for prevention of HIV/AIDS.	30%	12% (n=960)	79% (n=336)

E) CAPACITY BUILDING AND SUSTAINABILITY PLAN AND OUTCOMES CHART-CHILD SURVIVAL X-PC1 MALUKU, INDONESIA

Goal(from DIP)	End-of-project objectives(DIP)	Steps taken to date	Outcomes
A) Improve system for recording and supervision of immunization coverage	1) Computerized network for immunizations operated by Maluku DOH staff at provincial and district levels 2) Computerized network used to used to calculate vaccine stocks	1)DOH staff have been trained in MANISE(an immunization recording software developed to be compatible with the Indonesian MOH recording system) 2) MANISE has been installed in both provincial and district computers. Results are tabulated at district level and sent to the province on diskette.	-MANISE is functioning in all districts -It has been slated for trial in five other provinces: Sulawesi Tengarra, Irian Jaya, Timor, Kalimatan, and Nusa Tenggara. -A generic MANISE program has been developed for use in all parts of Indonesia -The govt. has adopted MANISE because: a)it saves time by eliminating manual computation and graphics b)it is in Bahasa Indonesia c)costs less to store and transport data
B) Mobilize the community to increase attendance and immunization coverage at National immunization Week (PIN) posts. {activity not planned in DIP}	1) This activity was not originally in the DIP but came about as a social mobilization strategy to increase PIN attendance in 1995-97. The objective was to increase the proportion of schools and students encouraging attendance at PIN posts.(PAMUPIN)	1)PCI/LPPM formulated plan with the provincial PIN advisory committee in 1995 as a pilot project 2) Trained teachers and other staff about PAMUPIN 3) Teachers trained 4^{th}, 5^{th} & 6^{th} grade students to escort women to the PIN	-After successful participation of 840 schools and 37,000 students in 1995, the govt. initiatied and financed program expansion to 2,200 schools, with an estimated 12 1,000 students participating in the 1997 PIN. -PMOH showcased PAMUPIN to Minister of Health on his nationally televised '97 PIN site visit to Maluku

		4) Provide materials and yellow id armbands to PAMUPIN students 5) Developed a PAMUPIN "march" song , bumper stickers, and brochures 6) PCI/LPPM served on the PIN committee to help evaluate and plan PAMUPIN activities for 1996 & 97	-It has been suggested by other agencies that the govt. could use this concept for other programs such as vitamin A capsule distribution and environmental activities
C) Expand the provision of TT immunization to all women of child bearing age(14-45 years) not just pregnant women	1) Increased usage of new lifetime TT card and monitoring system to record the immunizations	1)A lifetime TT card developed with approval of DOH 2)Pilot distribution through the *posyandu* system with expansion to the whole province	-Lifetime TT card approved and printed -200,000 cards have been distributed and in final survey 25% of all women possessed the card -This card will be adopted nationally. UNICEF will print 42,000,000 plastic versions of the card
D) Increase coverage of School ***Pos yandu*** Training(PPAS) to increase *posyandu* attendance; and mothers and students knowledge of *posyandu* activities	1) Increase the PPAS program coverage to more than 600 rural villages	1)PPAS curriculum developed and approved by DOH & DOE 2) printed and distributed necessary materials 3) Selected 12 schools in every sub-district then trained teachers and other school staff at these schools	-PPAS curriculum and workbooks approved & printed -50 sub-district supervisors trained about PPAS -621 school teachers and 621 principals trained in PPAS -24,700 children from 878 schools trained in PPAS

		4)Teachers trained 4th grade school children in the curriculum	-New Zealand govt. provided additional funds to expand the program during CS X and to continue new schools in '97/'98 -Funding will be budgeted by the provincial govt. to continue and add an additional 5 schools per sub-district
E) Health Education training to improve health system staffs knowledge about *posyandu* health activities	1) Train 135 health center educators and 10 trainers of trainers	1) Conduct a training of trainers then train health center educators in education for *posyandu* activities	-Educators in 135 health centers were trained -Government of Indonesia funded the training for 35 of the health centers
F) Budget granted by the Provincial PMT for supervising promotion activities to increase attendance at ***posyandu***	1) Increase the number of social mobilization activities that involve local ***posyandu*** management teams in the planning and implementation	1)A sector of PMT members will coordinate local social mobilization activities 2) PC1 provided initial support for 4 months of promotion activities such as radio quiz shows, bumper stickers, and brochures	***-Posyandu*** kader Radio quiz shows have been conducted in all districts -Bumper stickers distributed province wide -Local district govt. Are continuing promotion activities with their own funding
G) Increased use of the ***Posyandu*** and improve maternal and child health services provided by TBAs	1) Conduct a refresher training of 1,500 TBAs	1) Develop approved TBA refresher curriculum 2) Conduct TBA refresher training	-This activity cancelled due to change in national MOH policy. A smaller training program was held funded by Union Texas(a private oil company)
H) Thepos ***yandu*** system expanded to increase coverage of mothers and children	1) Train 5 new ***pos yandu*** Kader in 200 villages	1)Employ previous approved curriculum to train new Kader in selected villages	-New ***kader*** were trained in 118 villages. However, govt.not able to fund as promised

			- Additional funding for 118 villages ***pos yandu*** Kader trainer was provided by AusAid
H) Increase government health staff and community ***correct*** knowledge about HIV/AIDS	1)135 health centers and their staff will receive HIV/AIDS training 2) 135 village HIV/AIDS village seminars will take place	1)Conducted baseline and final HIV/AIDS awareness survey 2) Designed an approved curriculum 3) TOT for health center staff 4) Health center staff train village leaders in the 10 surrounding villages near the health center 5) The village leaders encouraged to hold post-training meetings in each village	-135 health centers and 300 staff trained in HIV/AIDS - 107 HIV/AIDS training sessions conducted for community leaders -Village leaders conducted village meetings with 2,546 people attending -AIDSCAP funded the training for 88 additional trainings -LPPM was invited to conduct 8 privately funded workshops for 2,841 government and business leaders - LPPM will continue HIV/AIDS activities under a future USAID matching grant
1) A local partner organization will be formed by PCI/Maluku staff members to, legally and systematically, continue community health activity in Maluku beyond 1997.	1)LPPM able to obtain funding to continue functioning after CS X 2) LPPM able to continue providing service competently and independently	l)PCI local staff formed a local NGO , LPPM 2) LPPM registered with the govt. 3) Received on the job training from PC1 and VSO for management and technical areas	-LPPM began, in 1994, to diversify portfolio and donor base in preparing for PCI's closure in Maluku. -The Indonesian govt. has requested LPPM services for training after CS X

		4) Staff sent to outside training to improve their skills 5) In last year of project, LPPM developed its own identifying logo. LPPM also developed its own working relationship with the Government of Indonesia 6) PC1 introduced LPPM to govt. and international donors 7) LPPM was encouraged to write their own project proposals before the end of CS X	-LPPM has obtained additional funds for conducting its activities during CS X from AusAid, AIDSCAP, NZ Embassy, Indonesian govt. and other sources -Funding or potential funding after CS X from: a)NZ Embassy(PPAS) b) USAID HIV/AIDS grant c)McFarlane/Burnet will sub-contract LPPM for new AusAid project in 2 district d) Community Outreach Initiatives will sub-contract selected LPPM staff for training activities in East Kalimantan e) German Doctors in Developing Countries will contract LPPM for clean water f) UNICEF is a possible 1998 donor g) AusAid may contract LPPM for operational research

APPENDIX 1
Scope of Work

SCOPE OF WORK

FINAL EVALUATION OF CS-X

MALUKU PROVINCE

PROJECT CONCERN INTERNATIONAL

INTRODUCTION:

Project Concern International (PCI) has been involved in health and development activities in Indonesia for twenty-five years. In the fall of 199 1, PC1 began working in the Province of Maluku with support from a USAID Child Survival VII (CSVII) grant. This area was chosen by request of the MOH Director General for Community Health, Dr. Leimena, due to its delayed health development, and as the province had the lowest immunization coverage in all of Indonesia. The overall Child Survival Project design supported activities to improve ***Posyandu*** implementation and attendance focussing on improving immunization coverage while promoting the identification of high-risk births and appropriate diarrhea1 disease management. With favorable results the project received continued funding under Child Survival X (1994-1997). The extension builds on the success of the first project emphasizing improvement in MOH capability for health education, expansion of social marketing strategies, training of ***Posyandu*** staff and introducing HIV/AIDS interventions.

As part of the routine project implementation, PC1 is required to undertake a final evaluation. Unlike the mid-term evaluation, this evaluation is intended to focus on both the qualitative and quantitative accomplishments of the project. Results of the final survey will be reviewed. Qualitative aspects of project implementation will be assessed through interviews of project personnel and target populations with the aim of delineating the strengths and weaknesses.

Project Concern International's final evaluation for its CSX Project in Maluku Province will be undertaken from Sept 1 - 14, 1997. The evaluation team consists of three members:

1) Dr. Rita Leavell, Head of Party
   Public Health Consultant

2) Dr. Sumanto
   Health Technical Advisor
   Office of Human & Institutional Resource Development
   USAID/Jakarta

3) Mr. Keith Feldon
   Country Director&-mea
   Project Concern International
   California, USA

The representative from the Community Medicine of the National MOH has yet to be appointed. Dr. Stephen Robinson, Asia Regional Technical Advisor/Project Director will escort the team to the field.

REQUIREMENTS:

USAID/Washington has prepared the new Final Evaluation Guidelines for CS-X (copy enclosed). The evaluation team will use these guidelines to review the project and prepare a document for submission to USAID/Washington by September 30, 1997, the final day of the project. The team will visit on-going and completed project activities and interview principle officials and target personnel involved in the project. Travel will be required, as the province is extensive and few activities are being conducted in the capital of Ambon. The first day the team will be oriented and interview provincial level officials in Ambon. A schedule is attached. A trip is planned to SE Maluku to witness several typical activities in the field and get an appreciation for the geographic situation faced by the project in achieving its objectives.

Since only 12 days are given for the evaluation, the evaluation team can obviously view only a limited number of program sites and activities. Therefore, the team must limit its conclusions to those where it felt the given information was adequate and refrain from making comments on issues that could not be adequately reviewed. It should be noted that the purpose of this evaluation is to review Project Concern International's CSX program and not to review or critique any Indonesian Ministry of Health program.

FINAL EVALUATION SCHEDULE

Sun., 30 Aug	All team members present in Arnbon
	Continue orientation
Mon., 1 Sept	AM - Orientation at PC1 office PM - Continue orientation
Tues., 2 Sept	Observe PIN activities
Wed., 3 Sept	Travel by boat to Tual, capital of SE Maluku
Thurs., 4 Sept	Kei Kecil - Meet with SE Maluku Municipality MOH officials
Fri., 5 Sept	Kei Kecil
Sat., 6 Sept	Kei Kecil
Sun., 7 Sept	Rest
Mon., 8 Sept	Kei Besar
Tues., 9 Sept	AM - Travel by plane to Ambon PM - Meet with Project Director

Wed., 10 Sept	Ambon/Hila
Thurs., 11 Sept	Write-up report
Fri., 12 Sept	Present results to MOH/Maluku
Sat., 13 Sept	Rest or leave for home

LOGISTICS:

The evaluation team members will be booked into the Arnans Hotel, which is only 100 meters from the PC1 office. The hotel is a three-star hotel with swimming pool, tennis and squash courts.

The team will be provided an area in the PC1 office in which to review documents and work on the final document. Secretarial assistance, computers, FAX and e-mail will be available. Some project documents will be made available before departure to Ambon. Others will be available for review in the office.

Recreation is available on the weekend at several beaches on Arnbon Island and Kei Kecil for bathing or snorkeling. PC1 will assist in arranging transportation.

Since this is a malaria-endemic area, it is recommended that the team members take prophylactic measures in addition to bringing mosquito repellant. Accommodations in SE Maluku will be arranged so as to minimize the chance of exposure, but this is not a guarantee of a mosquito-free visit.

PC1 will arrange all transport from/to Jakarta and locally.

Your information contact prior to and during the evaluation:

Dr. Stephen Robinson
Project Concern International
P.O. Box 1094
Jl. Mutiara, 53
Ambon, Maluku, INDONESIA

Tel. 62-542-61891/65092/63045
Fax 62-542-26873
e-mail: corinit@indo.net.id

APPENDIX 2
List of Evaluation Team Members

List of Evaluation Team Members:

1) Dr. Rita Leveall, Head of Party
   Public Health Consultant

2) Dr. Sumanto
   Health Technical Advisor
   Office of Human & Institutional Resource Development
   USAID/Jakarta

3) Mr. Keith Feldon
   Country Director/Eritrea
   Project Concern International
   California, USA

4) Dr. Sri Durjati Boedihardjo
   Program Manager, Maternal & Child Health and
   Nutrition Department USAID/Jakarta

APPENDIX 3
Schedule for Evaluation

FINAL EVALUATION SCHEDULE

Sunday August 31	Arrival of Rita Leavell, Keith Feldon and Sumanto in Ambon No activity planned. Rest and review materials at leisure
Monday September 1	Orientation and review of evaluation plan Review of CS-X activities with Project Director
Tuesday September 2	Attend the National Immunization Week ceremonies in Ambon
Wednesday September 3	Boat to Tual, Southeast Maluku
Thursday September 4	Meet with MOH officials of Southeast Maluku Witness ***MANISE*** software use and cold chain management Meet with the Southeast Maluku *Posyandu* Management Team representatives Observe ***Posyandu*** activities: Sathean Village, Kei Kecil Sub-district
Friday September 5	Meet with MOE officials and teachers of Southeast Maluku/Kei Kecil Sub-district Visit School ***Posyandu*** Program: Dullah Ngadi Village, Kei Kecil Sub-district Observe ***Posyandu*** activities: Dullah Laut Village: Kei Kecil Sub-district
Saturday September 6	Visit School ***Posyandu*** Program: Danar Village, Kei Kecil Sub-district Interview Health Center Doctor, observe cold chain and PWS system Observe Southeast Maluku ***Posyandu*** Radio Quiz
Sunday September 7	Rest and review project as necessary
Monday September 8	Meet with MOE officials and teachers of Kei Besar Sub-district Visit School ***Posyandu*** Program: Fako Village, Kei Besar Sub-district Meet with Health Center Staff of Wakol Meet with Village leaders regarding HIV/AIDS activities
Tuesday September 9	Flight to Ambon Meet with Program Director
Wednesday September 10	Observe School ***Posyandu*** Program teacher training: Hila Village, Central Maluku Sub-district Evaluation team discusses findings and begins drafting report outline

Thursday September 11	Evaluation team discusses findings and drafts evaluation report Team prepares for presentation with the MOE and MOH
Friday September 12	Evaluation team presents findings to the MOE and MOH Team completes evaluation report
Saturday September 13	Rita Leavell, Keith Feldon and Sumanto depart

APPENDIX 4
List of Persons Interviewed

LIST OF PERSONS INTERVIEWED

Tual, Southeast Maluku

Dr. D. Anatototy	Director of Ministry of Health (MOH), SE Maluku
Ihu C. Refra	Director of Education Subsector MOH, SE Maluku
Bpk. L. Etwiory	Head of the Prevention of Infectious Diseases MOH, SE Maluku
Ibu H. Rahayaan	Head of the Family Welfare Organization, SE Maluku
Dr. Nurdin	Head of the SE Maluku ***Posyandu*** Management Team
Dr. BR Koedoeboen	Head of the SE Maluku Social Marketing Team
Bpk. P. Ingratubun	Director of Ministry of Education and Culture (MOE), SE Maluku
Bpk. I Rahawarin	Supervisor of Activities of the MOE

Kei Kecil Sub-district

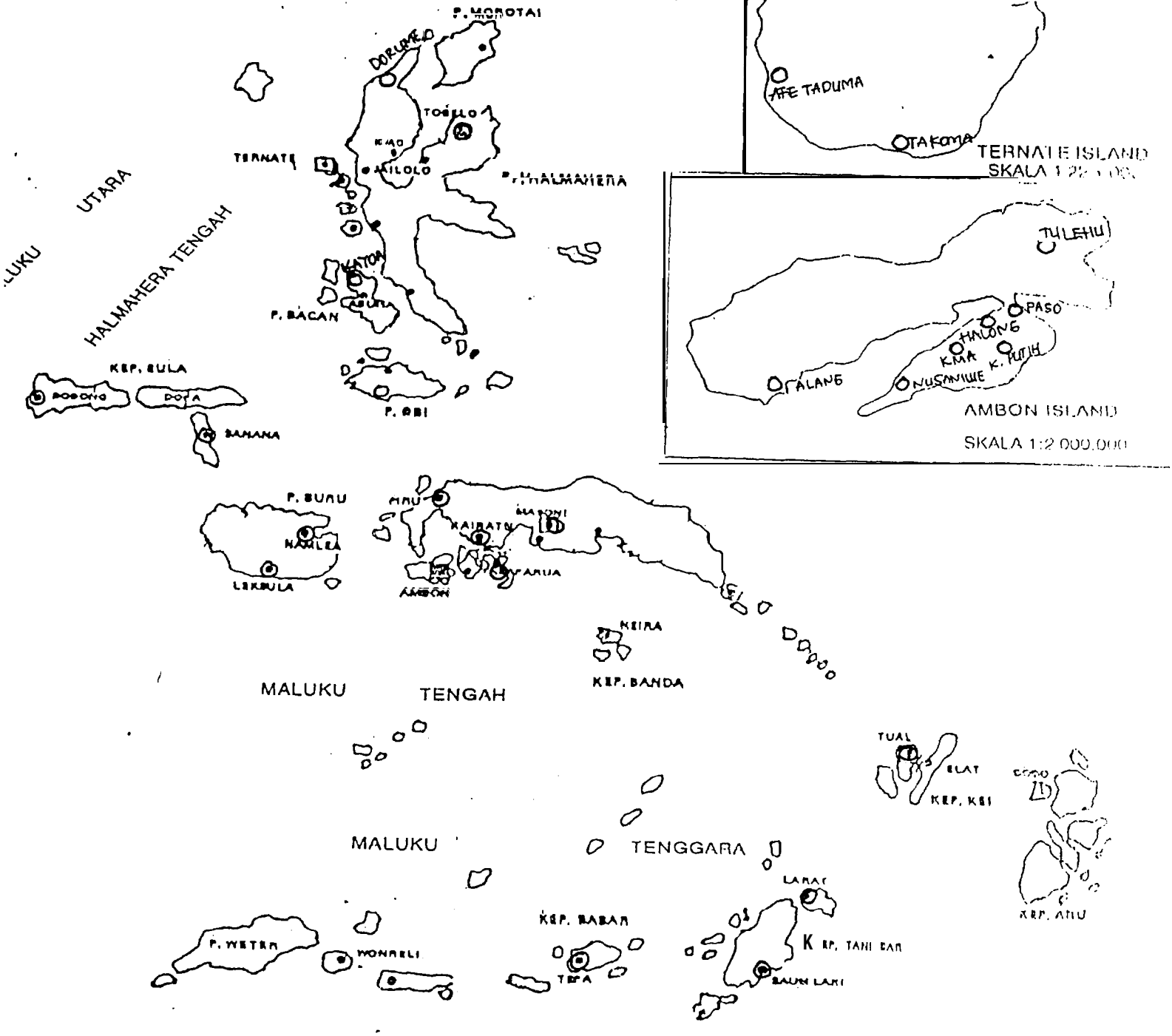
Posyandu cadres	Sathean village
Health Center Midwives	Sathean village
Mothers of children under five	Sathean village
Heads of schools and teachers	Kei Kecil Sub-district
Elementary school students	Kei Kecil Sub-district
Elementary school teachers	Kei Kecil Sub-district
Bpk. Faderubun	SD Negiri Dullah Ngadi principal, Dullah Ngadi village
Ibu Nabalin	SD Kristen Ohoiseb principal, Danar village
Bpk. Nabas Lutermas	Head of Danar Health Center

Kei Besar Sub-district

Bpk. A. Ur	Sub-district Head of Ministry of Education and Culture
Bpk. Kubangun	Supervisor of Activities of MOE in Kei Besar Sub-district
Heads of schools and teachers	Kei Besar Sub-district
Elementary school students	Kei Besar Sub-district
Bpk. HW Hukubun	SD YPPK DRY Shitanala principal, Fako village
Bpk. L. Fader	SD YPPK DRY Shitanala teacher, Fako village
Bpk. Y. Dangeubun	Head of the Wakol Health Center
Bpk. Man Rahman	Head of El Ralan Village
Bpk. Meky Hor	Head of Hor Kristen Sub-Village
Bpk. Mut Tanarubu	Head of Hor Islam Sub-Village
Bpk. Kundrat Karumbu	Head of Sirbun T Sub-Village
Bpk. Abdullab Lahmurin	Head of Weer Village

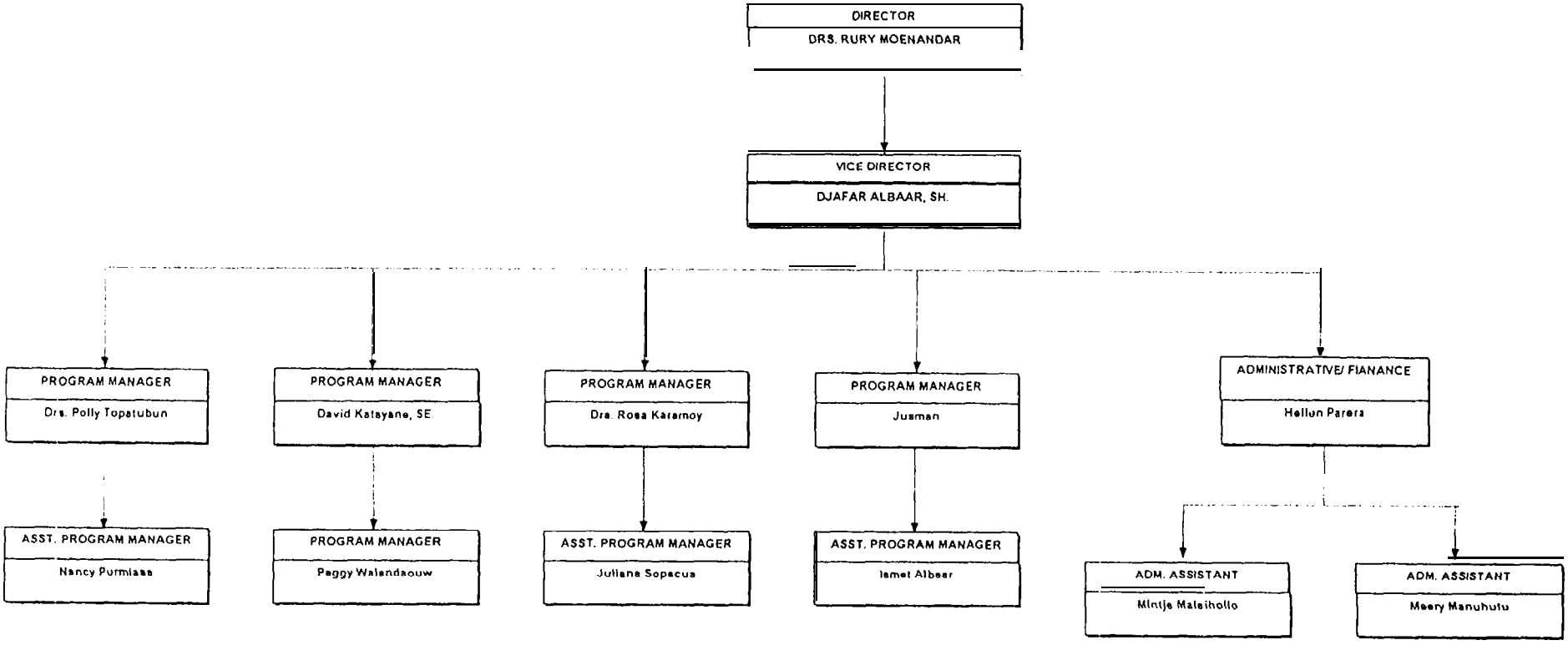
APPENDIX 5
Map of Maluku Project Areas

MALUKU PROVINCE

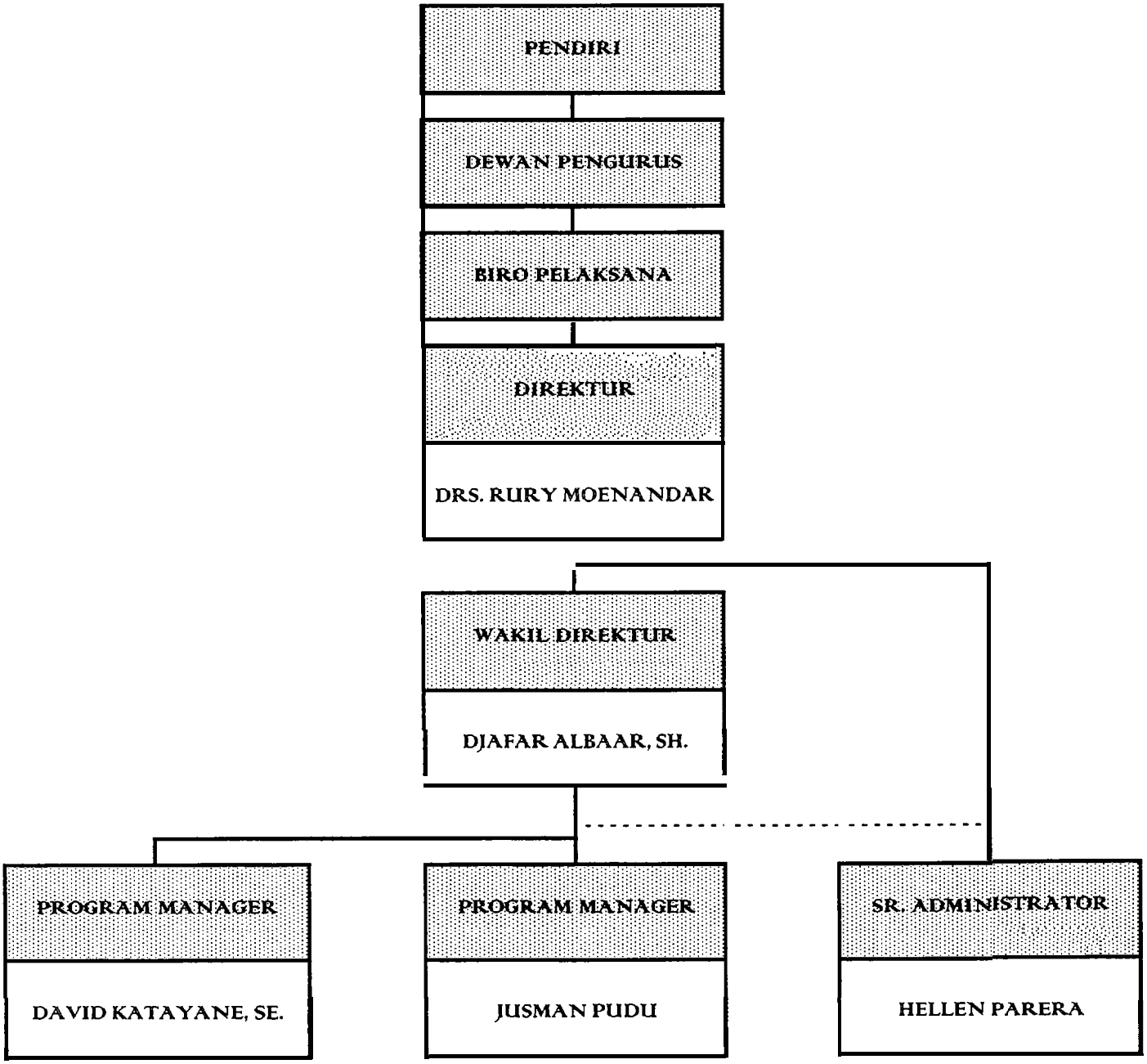


APPENDICES 6 & 7
Organizational Charts

LEMBAGA PENGEMBANGAN PEMBANGUNAN MASYARAKAT (LPPM) / MALUKU
ORGANIZATION CHART



LPPMORGANIZATIONCHART



APPENDIX 8
Staff Training

STAFF TRAINING PCI/LPPM STAFF
DURING CS-X PROJECT

NO.	NAME	DESCRIPTION	LOCATION	DURATION	DATE
1.	Rury Moenandar Sr. Project Manager	Writing of Reports	University of Indonesia	4 days	January, 1995
2.	Djafar Albaar PM North Maluku & HalTeng	With SR to Embassy & Other Donor Agencies	Jakarta	5 days	February, 1995
3.	Jusman HIS Coordinator	Computer Training	ALDCOM Jakarta	1 month	May, 1995
4.	Hellen Parera Executive Secretary	Administration & Financial Training	Yayasan YIS/Solo	9 days	June, 1995
5.	Rosa Karamoy Social Marketing Specialist	Meeting with Minister of Education & Culture	MOE Office / Jakarta		July, 1995
6.	Hellen Parera Executive Secretary	Rapid Needs Assessment Training for HIV/AIDS	Ambon	6 days	July, 1995
7.	David Katayane PM Central Maluku & Ambon Municip.	Rapid Needs Assessment Training for HIV/AIDS	Ambon	6 days	July, 1995
a.	Rosa Karamoy Social Marketing Specialist	Rapid Needs Assessment Training for HIV/AIDS	Ambon	6 days	July, 1995
9.	David Katayane PM Central Maluku & Ambon Municip.	Rapid Needs Assessment	University of Indonesia	7 days	October, 1995
10.	Farry Muntu Offie Manager	PCI World Conference	PCI/HQ San Diego	8 days	October, 1995
11.	Dr. J. Stephen Robinson Project Director	International AIDS Conference	Chiang Mai / Thailand	5 days	September, 199

STAFF TRAINING PCI/LPPM STAFF
DURING CS-X PROJECT

NO.	NAME	DESCRIPTION	LOCATION	DURATION	DATE
12.	Peggy Walandouw PM Assistant Central Maluku & Ambon Municipality	Review & Evaluation of Mother and Child Survival	Ciloto in Jakarta	3 days	February, 1996
13.	Rury Moenandar Sr. Project Manager	Semiloka HIV/AIDS	Hotline Surya/Surabay	7 days	March, 1996
14.	Nancy Purmiasa IEC Specialist	IEC Workshop	University of Indonesia	6 days	April, 1996
15.	Jusman HIS Coordinator	Computer Training	ALDCOM Jakarta	1 month	May, 1996
16.	Rosa Karamoy Social Marketing Specialist	Counseling STD & HIV/AIDS Training	Jakarta	14 days	May, 1996
17.	David Katayane PM Central Maluku & AMbon Municip.	Counseling STD & HIV/AIDS Training	Jakarta	14 days	May, 1996
18.	Rury Moenandar Sr. Project Manager	National Immunization meeting	Ciloto/Jakarta	3 days	June, 1996
19.	Rury Moenandar Sr. Project Manager	National Meeting for Prevention & Implementation for HIV/AIDS	Jakarta	5 days	July, 1996
19.	Hellen Parera Executive Secretary	Seminar for Women & Health Care	Jakarta	5 days	July, 1996
20.	Rury Moenandar Sr. Project Manager	Counseling Training from EPOCH Jakarta	Ambon	3 days	August, 1996

STAFF TRAINING PCI/LPPM STAFF
DURING CS-X PROJECT

NO.	NAME	DESCRIPTION	LOCATION	DURATION	DATE
21.	Peggy Walandouw PM Assistant Central Maluku & Ambon Municipality	Counseling Training from EPOCH Jakarta	Ambon	3 days	August, 1996
22.	Nancy Purmiasa IEC Specialist	Counseling Training from EPOCH Jakarta	Ambon	3 days	August, 1996
23.	Rury Moenandar Sr. Project Manager	National Seminar for Outreach worker	Yogyakarta	4 days	November, 199
24.	Rury Moenandar Sr. Project Manager	Behavior change communication – Curriculum Development Workshop	Jakarta	12 days	December, 199
25.	Polly Tapotubun PM South East maluku	Counseling STD & HIV/AIDS Training	Jakarta	5 days	December, 199
26.	Polly Tapotubun PM South East maluku	National Immunization Meeting	Cisarua	1 day	December, 199
27.	Rury Moenandar Sr. Project Manager	Behavior change communication – Curriculum Development Workshop	Bali	5 days	March, 1997
28.	Hellen Parera Executive Secreatary	Seminar for Youth and Health Care	Bukittinggi/Padang	5 days	March, 1997
29.	Rury Moenandar Sr. Project Manager	Behavior change communication – Curriculum Development Workshop	Manado	5 days	May, 1997

APPENDIX 9
Implementation of HIV/AIDS Activities

IMPLEMENTATION OF HIV/AIDS ACTIVITIES
BY LPPM/PCI
IN MALUKU PROVINCE

NO	DATE	LOCATION	TOTAL PARTICIPATION	MATERIALS	REMARKS
1.	JULY–AUGUST '95	DISTRICT	191	HIV/AIDS TRAINING	TOT PKM
2.	20/09/1995	AMB. MUNIC	86	HIV/AIDS TRAINING	POLICE DEPARTEMENT MALUKU
3.	11/11/1995	AMB. MUNIC	400	HIV/AIDS SEMINAR	QPM MOLLUCAN PASTORS
4.	20 –25/11/1995	AMB. MUNIC	27	HIV/AIDS TRAININQ	TOT PKM
5.	25/11/1995	AMB. MUNIC	54	HIV/AIDS TRAININQ	POLITICAL PARTY MEMBERS PDI
6.	28/11/1995	AMB. MUNIC	40	HIV/AIDS TAAININQ	FAMILY WELFARE COMMITTEE & WOMEN ORGANIZATION AMBON MINICIPALITY
7.	15/12/1995	AMB. MUNIC	160	HIV/AIDS SEMINAR	AMBON MUNICI.SERVICE OFFICIALS & STAFFS
8.	18–19/12/1995	MASOHI	40	HIV/AIDS TRAINING	MOSOUE 6 CHURCH YOUTH
9.	27/03/1996	PIRU	43	HIV/AIDS TRAININQ	GPM YOUTH CAMP
10	17/05/1996	AMB. MUNIC	24	HIV/AIDS DIALOQUE	HIGH SCHOOLS ORGANISATION
11.	21/05/1996	AMB. MUNIC	850	HIV/AIDS SEMINAR	MEMORIAL CANDLE LIQHT
12.	31 MEI. 1996	AMAHUSU	100	HIV/AIDS SEMINAR	CHURCH ORQANIZATION AT AMAHUSU
13.	1–3 JUNI 1996	KMA	140	HIV/AIDS SEMINAR	CHURCH ORQANIZATION FOR WOMEN AT AMBON MUNICIPALITY
14.	28 JUNI 1908	KMA	120	HIV/AIDS SEMINAR	STUDENT OF SMKK SCHOOL AMBON
15.	1–2 JULI 1996	KMA	200	HIV/AIDS SEMINAR	UNIVERSITY OF UKIM/AMBON
16.	22 JULI 1996	HALONG	60	HIV/AIDS SEMINAR	SEMINAR FOR HIV/AIDS HEAD OF CHURCH ORGANIZATION
17.	18 SEPT '96	KMA	40	HIV/AIDS SEMINAR I DISCUSSION	SMA NEQERI 45 SCHOOL IN AMBON
18.	23 NOV. '96	KMA	40	HIV/AIDS SEMINAR & DISCUSSION	CHURCH ORGANIZATION IN WASU. HARUKU SUBDISTRICT
19.	3 DES. '96	WAISARISSA	50	STD& HIV/AIDS TRAINING	YOUTH ORGANIZATION AT WAISARISSA VILLAGE AND SURROUNDED
20.	DESEMBER 1996	12 PUSKESMAS	262	STD & HIV/AIDS TRAININQ	HEAD OF VILLAGE. COMMUNITY LEADER AND RELIQIOUS LEADER
21.	JANUARY, 1997	19 HC	411	STD & HIV/AIDS TRAININQ	HEAD OF VILLAGE. COMMUNITY LEADER AND RELIGIOUS LEADER
22.	FEBRUARY 1997	15 HC	420	STD & HIV/AIDS TRAININQ	HEAD OF VILLAGE. COMMUNITY LEADER AND RELIGIOUS LEADER
23.	MARCH 1997	14 HC	378	STD 6 HIV/AIDS TRAININQ	HEAD OF VILLAGE. COMMUNITY LEADER AND RELIGIOUS LEADER
24.	JULY 1907	URAUR	60	STD& HIV/AIDS TRAINING	HEAD OF VILLAGE. COMMUNITY LEADER AND RELIQIOUS LEADER
25.	JULY 1997	HUNITETU	50	STD & HIV/AIDS TRAININQ	HEAD OF VILLAGE. COMMUNITY LEADER AND RELIQIOUS LEADER
26.	AUGUST 1997	PIRU	70	STD & HIV/AIDS TRAINING	HEAD OF VILLAGE. COMMUNITY LEADER AND RELIGIOUS LEADER
27.	AUGUST IQ97	AMBON MUNIC.	100	HIV/AIDS EDUCATION AND COUNSELINQ TRAININQ	CHURCH OFFICIALS FROM WHOLE MALUKU

PELAKSANAAN KEGIATAN HIV/AIDS
OLEH LPPM/PCI
PROPINSI MALUKU

NO	TANGGAL	TEMPAT	JUMLAH PESERTP	MATERI	KETERANGAN
1.	JUU-AGUST'QS	KABUPATEN	IQ1	FAKET LATIHAN HIV/AIDS	TOT PKM
2.	20 SEPT. 1995	K(M A	86	FAKET LATIHAN HIV/AIDS	POLDA MALUKU
3.	1II NOP. 1095	K(M A	600	F'AKET CERAMAH HIV/AIDS	PENDETA GPM se MALUKU
4.	LO-25 NOP 1995	K M A	27	F'AKET LATIHAN HIV/AIDS	TOT PKM
6.	25 NOP. 1 995	K M A	64	F'AKET LATIHAN HIV/AIDS	PEMUDA & WANITA PDI
6.	28 NOP. 1995	K M A	60	F'AKET LATIHAN HIV/AIDS	PKK DAN GOW KODYA AMBON
7.	15 DES. 1995	K:M A	150	F'AKET CERAMAH HIV/AIDS	PEJABAT & STAFF DINAS KMA
0.	18–19 DES 1995	MASOHI	40	F'AKET LATIHAN HIV/AIDS	PEMUDAGEREJA & REMAJA MESJID
0.	27 MAR. 1 996	F'IRU	43	P'AKET CERAMAH HIV/AIDS	KEMAH KEPJA PEMUDAGPM
10.	17MEI. iQQ6	K M A	24	DIALOG HIV/AIDS	OSIS SMA SE- KMA
11.	2!I MEI. 1996	K M A	650	CERAMAH& DISKUSI HIV/AIDS	MASYARAKAT MALUKU
12.	31 MEI. 1996	AMAHUSU	100	PAKET CERAMAH HIV/AIDS	JEMAAT GPM AMAHUSU
13.	13 JUNI 1996	KMA	150	PAKET CERAMAH HIV/AIDS	WADAH WANITA SE KLASIS KMA
14.	28 JUNI 1996	KMA	120	PAKET CERAMAH HIV/AIDS	SISWA SMKK AMBON
16.	12 JUU 1996	KMA	200	PAKET CERAMAH HIV/AIDS	MAHASISWAUKIM AM&ON
16.	22 JULI 1996	HIALONG	50	PAKET CERAMAH HIV/AIDS	SEMILOKA HIV/AIDS UNTUK UTUSAN KLASIS GPM SE-MALUKU
17.	18 SEPT/'96	F(MA	50	CERAMAH& DISKUSI HIV/AIDS	SMA NEGERI 45 AMBON
18.	23 NOV. '96	F(MA	00	CERAMAH& DISKUSI HIV/AIDS	JEMAAT GPM WASU. KEG. HARUKU
19	3 OES. '96	WAISARISSA	50	P'ELATIHAN PMS DAN HIV/AIDS	GENERASI MUDA DI DESA WAISARISSA DAN SEKITARNYA
20	DESEMBER 1 996	12 PUSKESMAS	2 5 2	P'ELATIHAN PMS DAN HIV/AIDS	KEPAIA DESA. TOKOH MASYAFIAKAT DAN TOKOH AGAMA
21.	JANUARI 1 QQ7	19 PUSKESMAS	411	P'EIATIHAN PMS &HIV/AIDS	KEPAIA DESA, TOKOH MASYARAKAT DAN TOKOH AGAMA
22.	PEBRUARI, 1 997	15 PUSKESMAS	426	P'ELATIHAN PMS & HIV/AIDS	KEPAIA DESA. TOKOH MASYARAKAT DAN TOKOH AGAMA
23.	MARET 1997	1 4 PUSKESMAS	370	P ELATIHAN PMS & HIV/AIDS	KEPALA DESA. TOKOH MASYARAKAT DAN TOKOH AGAMA
24.	JULI 1997	LIRAUR	60	P EIATIHAN PMS & HIV/AIDS	KEPALA DESA. TOKOH MASYARAKAT DAN TOKOH AGAMA
25.	JULI 1807	HUNITETU	50	P ELATIHAN PMS & HIV/AIDS	KEPALA DESA. TOKOH MASYARAKAT DAN TOKOH AGAMA
26.	AGUSTUS 1997	P IRU	70	P ELATIHAN PMS & HIV/AIDS	KEPALA DESA. TOKOH MASYARAKAT DAN TOKOH AGAMA
27.	AGUSTUS 1997	A .MBON MUNIC.	100	P ELATIHAN PENWLUH DAN K ONSELOR HIV/AIDS	PEJABAT GEREJA SE-MALUKU